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ABSTRACT

This paper provides general guidelines for psychiatric mental health workers who work with children and adolescents in a residential treatment center. Twenty-four questions commonly asked by therapists in these situations are posed and answers are discussed for each question. Topics covered include why some patients appear perfectly normal, the role of the therapist in relation to the child's teacher in a classroom setting, the responsibility of the therapist for the child's actions, supervising groups of children, establishing rapport, keeping control of a group, and handling one's feelings toward the children. Ways of handling patient requests are discussed and suggestions are given for dealing with children who threaten to run away, request contact with the therapist after discharge, act out, ask personal questions, flirt, ask the therapist to keep secrets, or complain of physical symptoms with no physical basis. Several areas of staff relations are also examined: helping other staff members, handling patient criticism of other staff members, disciplining patients of other therapists, discussing patients with coworkers, and handling disagreements over a coworker's decisions. The appropriateness of discussing a patient in his presence is also considered. This paper concludes with a list of six basic guidelines for workers in a residential treatment setting: (1) be consistent; (2) provide alternatives; (3) be a role model; (4) see clients as children first, patients second; (5) control is not everything; and (6) be yourself. (NRB)

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COMMON STRATEGIES WHEN WORKING WITH CHILDREN AND ADOLESCENTS EXHIBITING PSYCHO-SOCIAL PROBLEMS

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INTRODUCTION

Any psychiatric mental health worker who has worked with children and adolescents in a residential treatment center, often times feels bewildered and frustrated. The treatment and problems of this group seem so different than the management of adults. This paper is designed to provide general guidelines for psychiatric mental health workers in these situations. The reader should remember that these are only general guidelines, and that the actual response to the situation must include the therapist's knowledge of the individual patient and the situation. It is my hope that these questions and answers will serve to stimulate the psychiatric mental health workers awareness of the complexity of the milieu setting, as well as to stimulate the growth of the therapist as an individual.

QUESTIONS AND ANSWERS

WHY ARE THESE CHILDREN IN TREATMENT WHEN THEY APPEAR TO BE NORMAL?

Most therapists asking this question have some difficulty with the concept of hospitalization, as opposed to outpatient treatment. Children that end up in residential treatment usually have a long history of problem behavior, concurrent with a history of treatment that has failed to help maintain an acceptable level of behavior. Also, many of the"symptomatic" behaviors that brought the child into treatment (drug abuse, sexual acting out, school problems) are not available to the residential treatment setting due to its structure, making the therapist wonder why the child is a patient.

One of the basic tenets of residential treatment is that the emotional growth of the child will be enhanced through participation in a structured environment with clear-cut expectations of behavior. All children in treatment have specific areas of difficulty, which may be very individualized. For this reason, many parts of the structure may seem unnecessary to specific patients. Furthermore, no one, not even the most disturbed child, is "mad," "bad" or "crazy" all of the time. If the child's problems can be viewed as the result of a lack of internal controls, then it seems logical that there is a need for external controls until this is changed. These external controls are the therapeutic milieu, which serves to keep the child functioning while

he learns to develop his own internal controls.

Therefore, while some children appear to be placed in residential treatment inappropriately, the therapist must remember he is only seeing and responding to a small part of the child's overall behavior. When the therapist works closely with the rest of the treatment team, he is able to see the other aspects of the child's behavior (for example, with the family or in individual therapy) which generally puts the need for treatment in clearer perspective. It is important for the therapist to have as much information as possible about the child he is directly responsible for, but only after meeting and working with the child for a day or two. This delay helps the therapist to see the child more as a person, without preconceived notions from the past history.

AM I TO BLAME WHEN A CHILD ACTS OUT OR GETS INTO TROUBLE?

No therapist likes to have their children act out or have problems. Many think it is a direct reflection on their skill as a therapist. While it is true that some problems can be avoided or made less severe by the staff's awareness and intervention in certain situations, problems of some type will always arise. In reality, if there aren't some problems occurring, something is very wrong. If this is happening, chances are that the staff is aiding the child somehow in avoiding unpleasant or stressful feelings.

The therapeutic milieu is geared to help children take maximum responsibility for their behavior. It is easy for the therapist to say, "If I only had handled that situation better," or "It's my fault that John blew up today," when something happens. It is important to remember that, after the child leaves the milieu, things won't always go his way and people will do things that upset him. The child has to learn that he is the one who has to answer for his behavior, no matter what the therapist or anyone else does. If the therapist takes responsibility for the child's behavior, he is only delaying the process of the child accepting responsibility for himself.

Some children actively try to get the therapist to take responsibility

by blaming them for their acting out. Uusally they say something to the effect of, "If you didn't do so and so, I wouldn't be upset. It's your fault." In these situations it is good to remind the child that he is responsible for himself and your job is to respond to him according to how he acts. This helps the child to see his effect on the environment and gives him clues on how to function more appropriately. Above all, the therapist must be sure to show the child alternatives to avoid the unpleasant consequences of his behavior.

WHAT DO I DO WHEN I'M NOT SURE WHETHER A PATIENT'S REQUEST FOR SOMETHING IS APPROPRIATE?

Children in psychiatric treatment settings are often manipulators. For many, it is the primary method of getting their needs met from parents, teachers and others in authority. For this reason, it is a good idea to have some suspicion towards requests from patients you may not know very well, or when you are unsure of the perimeters of a situation.

Many beginning therapists feel that it is important to keep frustration levels low for the children and then to grant requests to avoid problems. This "always keeps them happy" attitude is quite unrealistic (Is anyone always happy?) and provides opportunities for manipulation. Therefore, don't be afraid to say, "No." Most of the time you will be right in doing so; other times it may be a mistake. Saying no will give you time to check with other staff or, perhaps even higher functioning patients you have a good relationship with, to see whether the request is appropriate.

Although some patients may become angry or upset when they get "No" for an answer, this is perfectly alright. Remember that you are working in a psychiatric setting, not a summer camp, and some degree of this type behavior is expected and even encouraged as representative of "real life" situations.

WHAT SHOULD I DO WHEN A PATIENT TELLS ME HE WANTS TO RUN AWAY?

When a patient makes a statement concerning running away or some other extreme form of behavior, he/she is trying to convey a message. He may have intentions of running away but there is something deeper happening. All such statements should be taken seriously and efforts should be made

to uncover what is happening with the child at the present time. Not attending to such statements puts the child in the position of having to act (actually running away) to be sure his message is heard. Probably if he really wanted to run away, he would have just done it without telling any staff or his friends (friends in the peer group have a habit of getting this information to staff also).

When a child states he is running away, staff should immediately take precautions to prevent this and make them known to the child. Sometimes, when the threat is really a request for a more secure environment, this is all that will be necessary. You should always try to find out the rationale the child has for these statements. Remember, he is asking for something from you in the most direct way he can.

IF A PATIENT ASKS TO MEET ME AFTER HIS DISCHARGE FROM TREATMENT, SHOULD I PLAN TO GET TOGETHER WITH HIM?

The role of the therapist in the residential treatment setting is to provide structure and consistency in the environment throughout the course of treatment. As residential treatment is long term, attachments are made and separation is sometimes difficult. Many children like to try to keep their ties with staff for security and to circumvent the separation process. Other times, children may have developed strong emotional feelings towards the therapist and "test" the possibility of a relationship with a staff member by asking to see them outside of the hospital. The therapist must remember the purpose of treatment for the child and his role in that treatment.

The discharge process is a key part of therapy, when the child prepares to take what he has learned back to school, home and the community. This is a stressful time for both staff and patients. While the therapist has spent time developing a relationship with the child, he must realize that it is time for it to end when discharge occurs. A good approach to dealing with this event with the child is to be open with the feelings you have about the child leaving (proud of his progress, missing him etc.) while discussing the reality of him having to leave. Usually it helps to remind the child that he will have his parents and outpatient therapists to help him if he needs it, but that your role with him is ending.

When a child is less dependent, it may be fine to tell him to call you (at work) to say how he is doing. It is our experience that you may get one or two calls and that will be all, as the child becomes more involved with outside interests. Other children may need a more clear cut separation, in which case the therapist can encourage the child to be independent after discharge. In all cases, it is wise to discuss the most appropriate response with your supervisor.

Under no circumstances should the therapist give the child his home phone or address! We can think of nothing worse than to come from work to find a former patient in front of the house after a fight with his parents or constant phone calls when things aren't going well for the child at home. This causes problems for all and makes the transition from inpatient to outpatient therapy almost impossible. It is always in the best interests of the child to help him see a clear cut ending to the relationship.

IF A PATIENT I DON'T KNOW WELL IS ACTING OUT, WHAT SHOULD I DO?

In any situation where a therapist is not familiar with a particular patient, caution should be exercised. With acting out patients, the first thing to do is to get some assistance in dealing with the problem. This "backup" person may know more about the patient and his problems and just having someone with you can help to diffuse a situation. The therapist must at all times remain calm and in control of the situation, even though you may feel you are not in control. It is important to convey to the patient that you are in control and that you are aware of his feelings and concerns. Despite the fact that all children and adolescents are individuals, they will almost always respond well to firmness and authority as long as they are presented with reason and respect.

AM I INTERFERING IF I OFFER TO HELP IN A SITUATION BETWEEN STAFF AND PATIENT THAT APPEARS TO BE POTENTIALLY DANGEROUS?

Offering to help can never be construed as interference in any situation on the milieu. The milieu functions as a therapeutic community and, as such, staff are expected to help and support each other. There are a number of ways that staff can make themselves available to support each other but it

is often difficult to handle alone. This awareness is often hard to teach new staff who feel they may be "stepping on toes" with more experienced when they offer assistance. However, it is better to offer your help than to assume that everything is under control or there are no problems when patients and staff are having a confrontation.

The simplest way to determine whether a fellow staff member needs assistance is to ask. This won't interrupt their interaction and, if the staff member is uncomfortable with what is happening, he will gladly accept your offer to either help with the resolution of the problem or the support of being there while he handles the situation. Often, just standing by silently can be supportive, with the staff member able to give non-verbal cues through eye contact or hand gestures to communicate his need for support.

Never enter a situation without first checking with the staff person's relationship with the patient and could have serious repercussions with the patient if you try to resolve the problem without knowing fully what is happening.

Remember, ask your colleague if he needs your assistance before doing anything, and if you feel uncomfortable in any situation, don't be afraid to ask for help. The milieu functions more effectively through staff support and communication.

HOW CAN I POSSIBLY SUPERVISE 10 OR 12 KIDS ALL AT ONCE?

Having to supervise a group of disturbed children is a tremendous responsibility. Many beginning therapists feel overwhelmed with having to watch an entire, active group to keep things under control. This is especially true with younger children whose level of activity seems to be amazing at times.

The key to supervising a large number of patients is <u>position</u>. The therapist should always try to place himself where he has a direct line of sight to all children in the group. For example, when walking through the hall with a group, it is best to stay behind them where you have a clear field of vision over everyone. In a dorm or cafeteria setting, this may not always be possible. In these situations, it is best for the therapist

to keep moving through the different areas where the children are active. Letting them see you often gives the impression that they are being supervised closely, even though there may be times when they are out of sight briefly. The therapist who keeps a low profile (usually explained as letting the children have some "freedom") is asking for problems.

Remember, no matter how diligent you try to be, something is bound to occur at some point. The next best thing to preventing problems is catching them when they occur and dealing with them. The therapist's job is never one or the other.

WHEN I AM IN SCHOOL OR OTHER ACTIVITIES, WHAT IS MY ROLE IN RELATION TO THE TEACHER?

Treating disturbed children is a difficult task. In order to be effective, it is important for all members of a treatment team to work together closely. When the therapist brings his group to school or activities, it is often tempting to turn them over to the teacher and take a back seat to the treatment process. The therapist must remember that, although the teacher is in charge of the activity, his role is to assist and support as much as possible.

Many children rebel against the added structure of activities or have a history of school problems that make it difficult to perform in the areas. Besides maintaining discipline in these instances, school and activities are an excellent time for the therapist to interact with the children on a more individual level. It is also an opportunity to be more than an authority figure to the children by helping and supporting them in the completion of tasks or projects.

All teachers and activity therapists will be glad to have your help and will also help you to be most effective with the group in this setting.

HOW DO I GO ABOUT ESTABLISHING RAPPORT WITH THE CHILDREN?

Many beginning therapists feel they have to be very careful and very formal when attempting to begin a relationship with disturbed children. Often they are quiet and try to observe how others interact and model this behavior. Consequently, they can become rigid and, at times, timid in approaching the children. The best approach in establishing rapport is

to be open and honest in relating your experiences in getting to know the child and his treatment setting. Look for cues in the child's response which suggest his desire to talk or listen as the relationship is established. Silence is fine at times in communicating acceptance of a youngster but can be problematic if their behavior necessitates a direct verbal intervention.

All children are skillful observers of human behavior and will usually see through any facade the beginning therapist puts up due to his/her discomfort in a situation. Above all, be yourself and use common sense. Being too open can have the same effect as being too rigid. The child will sense your discomfort and feel uncomfortable himself.

WHAT "CLUES" TELL ME I'M LOSING CONTROL OF A GROUP?

No individual child or group of children loses control or acts without warning. No matter how angry or upset they are, they are also afraid, so it is often possible to pick up "clues" that something is wrong or about to happen. This is mainly because they want to be sure the staff will be able to deal with the situation safely. Often the clearest message comes from the child in the group who is not having problems, as he is afraid of what might happen to him if the group or a peer acts out.

The following are indications that something is wrong with a group and the therapist needs to pay closer attention to the children or make some sort of intervention:

1. Noticeable increases in noise level in the group.
2. Secretive behavior or tendencies to withdraw from the main body of the group.
3. Angry reactions to common, everyday requests.
4. Over reacting to peer's behavior.
5. Increase in attention-seeking behavior.
6. Group member making attempts to get out of certain situations or activities.
7. Children's reports of concern or fear of a peer or his behavior.

It is impossible to list all of the indicators for potential acting out; however, the therapist must be aware of the most common situations where acting out can occur. For example, the transition between structured activities right after a difficult family meeting or group therapy and cafeteria or dorm times are all times and areas associated with a high

probability of acting out.

The therapist must try to be aware of any changes from the group's usual or average functioning and find out why it is occurring. Awareness of the potential for acting out is its best deterrent.

WHAT SHOULD I DO WHEN I FEEL LIKE I'M LOSING CONTROL OF A GROUP?

There are a number of feelings which may suggest that a therapist is losing control. Sometimes it can be a vague, uneasy feeling or a response to some overt problem with the children. Whenever a staff member feels he is not in control, for whatever reason, he should ask for assistance. There is usually always someone available to support the therapist. At times, just having someone as a "back-up" allows more latitude in resolving a problem with a group. Other times, it may be helpful for the patients to see staff support in problem situations.

The therapist is viewed as a powerful person in the milieu, and when the children perceive his discomfort in handling a situation or his not feeling in control, they can react strongly. It is important that the therapist maintain a calm appearance no matter how he may be feeling inside. This is admittedly difficult but, with practice, it is possible and is often enough to help maintain control of a group. There is nothing some children like better than to get the person supervising them angry or flustered. Not responding according to their expectations takes away the gains from such behavior.

Each therapist in the milieu will decide independently how much behavior they can tolerate. This may vary widely with some staff comfortable in situations that others view as marginally under control at best. Using the guidelines set forth by the institution, decide what is tolerable to you and be consistent with it. Don't be afraid to react to clues that the group is losing control, and above all, don't be afraid to ask for help. No one will think less of you for needing help from time to time. In fact, they will probably respect you more for your judgement. After all, it is much easier and safer to <u>maintain</u> control with help than to <u>re-establish</u> order when the group behavior becomes out of control.

WHAT DO I DO WHEN A PATIENT TELLS ME SOMETHING AND ASKS ME TO KEEP IT A SECRET?

There are no "secrets" within the milieu. The free flow of information between staff is essential to provide a consistent structure for the patients. Requests to keep secrets are usually the child's attempt to "test" the therapist concerning how he will respond to such requests. In the child's eye, a therapist who will keep secrets has taken one step away from being a staff member and one step towards being "one of the kids." This person's authority and support are seriously undermined.

The therapist should be straightforward when such requests are made. The child should be made to know that it is your responsibility to pass on information but that you will be careful in your judgement of who needs to know this information. Often it is helpful to express your discomfort at being asked to keep secrets when it is something other staff need to know about.

Contrary to popular belief, this approach will not damage your rapport with the children. Usually it will enhance it, as you will be viewed as a strong individual who helps maintain a safe environment. Most kids want their "secrets" passed on to someone or they would keep them to themselves in the first place.

WHAT RESPONSE SHOULD I MAKE WHEN A PATIENT ASKS QUESTIONS ABOUT MY PERSONAL LIFE?

Most children have their own ideas and conceptions about the adults that work with them, stemming from their past experience or some fantasies that they think of concerning certain adults that are important in their lives. It is natural for children to ask personal questions, although their motives in doing so are not always clear. The therapist must use caution and good judgement in deciding how far to go with his/her own personal disclosure.

Some children may be genuinely interested in the therapist's life because of their good rapport with him; others may be searching for

confirmation of positive or negative attitudes they have developed towards this person over the course of treatment. Sometimes the intent of the question can be discovered by asking the patient what he thinks the answer is. For example, when a child asks if the therapist is married and has children, the therapist can ask the child to say what he thinks to get some ideas about how he appears to him.

Some children may ask questions in areas that make the therapist very uncomfortable, which may be accidental or by design to evoke a reaction from the therapist. Probably the best response in such a situation is to say, "We aren't here to talk about me. I'm more concerned about you and your problems." Or simply, "Why is it important to know about me?" These statements usually enable the therapist to get a response to use in channeling the interaction into other areas, if he desires.

There are times when the therapist self-disclosure is helpful to the therapy. This is usually useful to role model the expression of emotions or a response to a stressful situation. The therapist must use his judgement in deciding how much to disclose in any instance.

WHAT DO I DO IF A PATIENT "FLIRTS" WITH ME?

It is very common for children and adolescents to "flirt" with the staff. Children and adolescents frequently look up to and admire persons who are older and have positions of power. In addition, adolescence is a time of finding one's identity, which also includes exploring one's sexual identity. Many of the patients have also come to realize that by "flirting" they can frequently obtain whatever they want.

As a therapist, you have a moral, ethical and legal responsibility not to encourage or accept the sexual or manipulative intent of the flirting but to gently, but objectively, look at the "why" behind the flirting. What needs is the patient expressing; what is he/she looking for?

If the flirting continues, it might be wise to ask yourself honestly if you have in any way encouraged this response. If the answer is "Yes," it is imperative to talk over these feelings with your supervisor. Remember, flirting may be normal for the patients as they experiment with new behaviors; however, it is not an appropriate response to use with any patient or family member. How you respond to flirting in your personal social life is, of course, your decision.

IS IT NORMAL TO HAVE "FEELINGS" TOWARDS PATIENTS?

Yes, it is quite normal to have"feelings" towards patients. These children are people that evoke natural feelings in all of us; however, as therapists, our job is to listen objectively. Also, these patients may have characteristics that evoke negative feelings in us.

As a therapist, you have a responsibility to be objective, not subjective; to have empathy, but not sympathy, and to not get "hooked" into a particular individual's needs, but rather the person as a whole. Remember, once you can no longer see the process (i.e., the necessary separation to listen and respond therapeutically), you can no longer help the patient.

If you find yourself thinking about a particular patient more than others, if you find yourself extremely disturbed, angry, sexually attracted to or overly gentle or extremely harsh with a patient, you are too involved. (You have feelings which you are no longer controlling.)

It is essential to speak with your supervisor before these feelings overrule your normal judgement. He/she may suggest that you stop working with the patient,. work through your feelings, help you to use these feelings productively or suggest that you seek outside help.

IF I GET ANGRY WITH A CHILD, HOW DO I KEEP FROM SHOWING IT?

One of the facts of life is that people do get angry with each other. Sometimes it can be a therapeutic experience for the child to see the effect he has on the people in his environment and to have someone demonstrate angry feelings in an appropriate manner towards him. Therefore, they may be nothing wrong with expressing your anger towards a child; however, it is one thing to express this anger in an "I" statement and quite another to ventilate or act out your frustration or anger over the child's behavior. The therapist should always be aware of his/her own feelings (i.e., Why am I angry? Why do I want to express this to the child?) and use this awareness to temper his/her judgement of what to express and in what way. The graphic experience of knowing how his behavior affects others and the modeling of appropriate ways to express angry feelings can be one of the most important learning experiences the child has throughout therapy.

SHOULD I TELL A PATIENT HOW I FEEL ABOUT HIM?

As stated previously, there are patients that we like and dislike. At times these feelings may be extreme and it is imperative that we begin to examine our own feelings and behavior before they interfere with the therapeutic process. It is also important to talk over these feelings with a supervisor in order to deal with the patient in a professional manner.

As therapists, we give continuous feedback to patients on their behavior. We should aim to give the message that we do indeed "like" the patient but either do not like or really approve of how he/she is behaving.

When a patient asks how do we feel about him, there is usually a reason for the question, i.e., we just set a limit on his behavior, he/she has a need to be liked, he/she likes us, etc.

The answer to the question should be, "Yes, I like you, but I wonder why you are asking now." By putting the question back to the patient in that way, you are more likely to elicit the real reason for the question and then can deal appropriately with the response.

HOW SHOULD I HANDLE A PATIENT'S CRITICISM OR COMPLAINT ABOUT ANOTHER STAFF MEMBER?

There are a number of possible reasons why a patient will complain about a staff member. He may be upset over a decision a staff member made, he may be attempting to manipulate a change in decision or he may have a valid complaint against that person.

In all cases, it is important for the staff member to listen to the complaint and attempt to process the reason behind it. It is essential that the patient feel his complaint is heard, no matter what the outcome may be. It is very important that the staff member refrain from making promises or changes in regards to another staff member's decision without first checking with that person.

If you determine that the patient has a valid complaint against a staff member, you may feel comfortable approaching the person to gain more information or speaking directly to your supervisor. At no time should you appear to take sides with the patient against the staff member. When you

feel that the complaint is valid, remain neutral until the entire situation is known.

WHEN IS IT APPROPRIATE TO TALK ABOUT A PATIENT IN HIS/HER PRESENCE?

It is often a useful technique to discuss a patient with another staff member while he is present. Usually, this should take the form of, "I'm concerned about John because he ....." or "John is having a difficult day because of ....." This approach is useful because the patient is made aware of the staff's communication concerning him, making it more difficult to split or manipulate staff. Also, it is an excellent opportunity for the patient to hear a "capsule summary" of his behavior and its effect on those around him.

As a general rule of thumb, it is inappropriate to discuss a patient in this way in front of his peers, which can be considered a violation of confidentiality. The only permissable exception may be when two or more patients have been involved in an incident and are being addressed as a group, or in a group therapy setting where sensitive or confidential information is already known or must be utilized in the course of therapy. It is also inappropriate to use such a technique to ventilate anger or frustration over the patient's behavior.

WHAT DO I SAY TO A PATIENT WITH MANY PHYSICAL COMPLAINTS WHEN I KNOW THEY DON'T HAVE A PHYSICAL BASIS?

All complaints, whether organic in nature or not, mean the patient is uncomfortable.

Often it is easier for a patient to say, "My head hurts." rather than "I hurt". The complaints can be on a conscious or unconscious level. Patients that are admitted to a psychiatric hospital have usually had a complete physical ruling out any neurological or medical conditions. During the course of hospitalization, if physical complaints do arise, they should be thoroughly checked out. Patients on medications can have side effects and adverse reactions which necessitate medical attention; however, once a symptom or group of symptoms has been checked and found to have no physical basis, the therapist needs to observe for a pattern. When do these complaints

occur? What is happening with the patient? What kind of complaints are they? Do they help them to avoid situations? When the therapist can form a hypothesis about the complaints, he/she can respond therapeutically to what the patient needs. Many times a complaint is just the patient's way of asking for attention and help. In our society, we think it is okay if something physical hurts but not if something does not feel right. Thus, patients, especially psychiatric patents who have a lot of anxiety, learn early to make their complaints concrete if they want them to sound real; however, the therapist should exercise caution towards the tendency to categorically think "physical vs. emotional" cause, which may lead to significant delays in the identification of legitimate physical problems. If the therapist thinks in terms of "physical and emotional" causes, he keeps an open mind and avoids inadvertently giving the patient the message that the complaints are not viewed as serious or valid.

WHAT SHOULD I DO IF I SEE A PATIENT I'M NOT DIRECTLY RESPONSIBLE FOR ACTING INAPPROPRIATELY?

Many therapists see children from different groups or treatment areas throughout their work day. When these children are engaged in some type of subtle, inappropriate behavior, the therapist often feels unsure of how to address the situation. Again, it is useful to remember that another name for the therapeutic milieu is therapeutic community. In this situation, a good rule of thumb is to treat all patients the same as you would treat those you are directly responsible for. This attitude helps to make the milieu consistent by giving the patients consistent expectations of how they should be behaving. Total consistency is impossible, but being assertive with all patients is a step in that direction and will help to make everyone's job a little easier.

IS IT APPROPRIATE TO TALK TO OTHER STAFF ABOUT THE CHILDREN I WORK WITH?

One of the most important rules of the milieu is that there are no secrets. Staff who are members of the patient's treatment team need full access to all information regarding his behavior in order to be effective therapeutically. In addition, other staff who may come in contact with the patient need to know about him, even though their contact may be

infrequent. While strict confidentiality is essential outside the treatment facility, informal discussion of behavior and events among staff within the hospital help to keep up the flow of information that keeps the therapeutic community effective and efficient.

Many patients talk to the staff and ask them to keep the conversation confidential. All staff should be careful not to make promises of this nature to any patient and make it very clear that any relevant information they disclose will have to be passed on to other members of the treatment team. Contrary to popular belief, this does not restrict patient's talking to the staff, but seems to make them feel more comfortable and secure in their relationships with their therapists.

IF I DISAGREE WITH A CO-WORKER'S DECISION, SHOULD I TELL HIM IMMEDIATELY TO HELP THE CHILD?

Differences in opinion concerning treatment often arise in residential treatment settings. Every therapist has his own personal style in dealing with problem behavior. With a large number of children, each therapist has some patients he knows better than others and deals with them differently. These differences are the backbond of the milieu, contributing to the personal growth of the staff as well as the children. It is always good to discuss differences in treatment approach, but this must be done within certain guidelines.

Differences in opinion should never be discussed in front of the children. Consistency suffers when the children are able to see staff disagreeing, as it gives them the ammunition to split staff and manipulate the milieu by playing one staff against another. Many patients are adept at this, having done it with their parents for years. Similarly, once a decision has been made, it must be followed through. Even if you don't agree with it, do it until you can discuss the rationale for it with other staff. Not following through on other staff's decisions places them in a precarious position when future decisions are made. It would be wrong to give any patient the message that certain staff's decisions are unimportant or inappropriate. That person's credibility will suffer and his future

dealings with the children will be greatly complicated.

When differences in opinion are discussed, don't be afraid to listen. Often staff disagree with decisions because they aren't aware of all available information and hypotheses. Also, there may be a number of alternatives in dealing with one specific situation. Each may be equally effective, so there are really no right or wrong answers in many cases.

Changing a decision after such a discussion doesn't necessarily harm consistency in the milieu. Many times staff can provide new information or a new perspective on a situation which will require a change. The key in this situation is to think through what needs to be done with the child to show him that staff communicate with each other in decision making in the milieu. An excellent technique for this is to discuss the child and his behavior with him present, always being careful not to undermind any decisions already made. This gives the child feedback on his behavior while at the same time showing him how staff make decisions in conjunction with each other.

CONCLUSION

The job of milieu therapist or child care worker is both difficult and demanding. There are many decisions to be made on a daily basis and a number of effective ways to respond to the behaviors that the children manifest. An extensive treatment of all possible problems faced by the child care worker is beyond the scope of this project. In concluding, however, we would like to offer the following guidelines to help in the effective management of all problem behaviors in the residential treatment setting.

1. Be consistent. Try to respond to similar situations in the same manner.
2. Provide alternatives. Give the child a feeling of responsibility for his actions.
3. Be a role model, not a friend. Your job is to manage and provide a consistent environment for the child, not to "rescue" him from his problems through your personal relationship with him.
4. Don't forget that you are working with children first, patients second. Some behaviors are perfectly normal for children in any setting.

5. Control is not everything. Over controlling has the same negative effect as too little control. It's okay to lose a battle to help win the war.
6. Be yourself. Children are perceptive. Being aware of your own feelings will help you do all of the above.